HIPAA Managed Care Transactions

Michigan Department of Community Health
April 17, 2003

Agenda

- Welcome
- Glossary
- Transaction Overview
- 834 Benefit Enrollment
- 820 Premium Payment
- 837 Encounters

Glossary

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Glossary

HIPAA/Industry Term	Medicaid Term	Description
Claim	Invoice	A single paper form, or a collection of services by a single billing provider for a single patient, billed at one time.
Service Line	Claim Line	A single service generally associated with a procedure code.
Replacement	Adjustment	A billing provider's request to change a previously submitted claim.
Void/Cancel	Adjustment	A billing provider's request to void a previously submitted claim.
Health Care Claim Adjustment		The difference between the billing provider's usual charges and the paid amount. The reason for the difference is described through the use of Health Care Claim Adjustment Reason Codes.
Subscriber	Recipient/Beneficiary	The individual who is enrolled in Medicaid and receives services.
Billing/Pay-to Provider	Provider	A hospital, nursing facility, physician or dentist that submits claims to be reimbursed for care they provide to patients (subscribers).

HIPAA EDI Terminology

HIPAA ANSI X12 Term	Medicaid Term (if applicable)	Description
Transaction		The exchange of information between two parties to carry out financial or administrative activities related to health care.
Loop		A repeating section in an EDI transaction.
Segment		A group of related data elements within an EDI transaction.
Simple Data Element		The smallest unit of information in an EDI transaction.
Composite Data Element		A more complex unit containing two or more simple data elements.
Delimiter		A character used to separate data elements in an EDI transaction.
Qualifier		A data element that describes the type of information that is to follow in an EDI segment.

Transaction Overview

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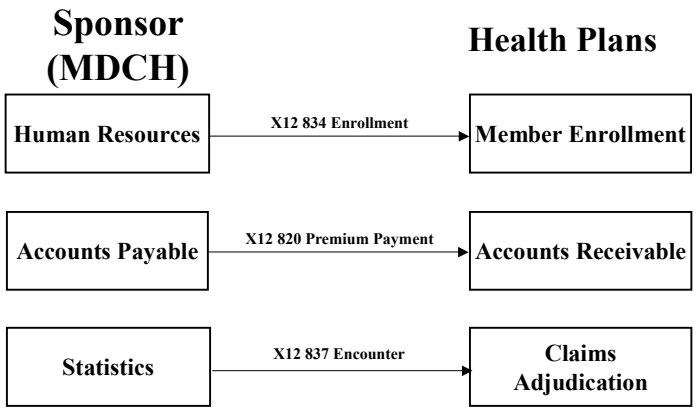
HIPAA Transactions

- Transactions prior to treatment
  - Eligibility Verification (270/271)
  - Authorization/Referral (278)
- Claims and related transactions
  - Claims (837)
  - Remittances (835)
  - Claim Status (276/277)
- Managed care transactions
  - Enrollment (834)
  - Premium Payment (820)
  - Encounter (837)

Managed Care Transactions



834 Benefit Enrollment and Maintenance

Michigan Department of Community Health
April 17, 2003

834 Overview

834 Overview

- The 834 is used by a sponsor to transfer enrollment information to a payer

  State Medicaid Programs must use the HIPAA-mandated 834 transaction when they enroll Medicaid recipients into contracted managed care plans

- The 834 can provide either periodic enrollment updates or full file audits

- Coordination of benefits information is transmitted with the 834, rather than with remittance transactions

MDCH 834 Transaction

- Goal: Implement a HIPAA 834 transaction that supports current MDCH enrollment business practices

- The following provider types will receive the 834 transaction:
  - Medicaid Health Plans (MHPs)
  - Children's Special Health Care Services -- Special Health Plans (SHPs)
  - Program of All-inclusive Care for the Elderly (PACE)
  - Health Kids Dental (HKD)
  - Community Mental Health -- Prepaid Health Plans (PHPs)

MDCH 834 Transmission Schedule

The HIPAA 834 transaction will be transmitted on a schedule that is consistent with the current timing of the proprietary transactions:

MHPs and SHPs	834
Card Cut Off (3653)	Audit
First of the Month (3653S)	Update
Weekly (4684)	Update
Daily (4276 Maximus)	Update
PACE	
Card Cut Off (3653)	Audit
First of the Month (3653S)	Update
HKD	
First of the month (Delta Dental Plan of MI Standard Eligibility File)	Audit
PHPs	
Card Cut Off (4396)	Audit

834 Transaction Detail

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834 Transaction Structure

ST 834

1000A Sponsor Name
1000B Payer

Table 2 -- Detail

2000 — Member Level Detail

2100A — Member Name

2100G — Responsible Person

2300 — Health Coverage

2320 — Coordination of Benefits

2000 — Member Level Detail …

SE 834

Table 2 – Detail Level

ST 834

1000A Sponsor Name
1000B Payer

Table 2 -- Detail

2000 — Member Level Detail

- Subscriber Number
- Member Policy (Group) Number
- Medicare Plan Code
- Member ID Numbers
- Member Level Dates

Maximum 10,000 members per transaction

2100A — Member Name

- Member Name
- Member Residence

2100G — Responsible Person

2300 — Health Coverage

- Plan Coverage Description
- Health Coverage Dates
- Health Coverage Policy Number

Health Coverage loop may repeat

2320 — Coordination of Benefits

May Repeat 5x/Health Coverage Loop

2000 — Member Level Detail …

SE 834

2000 Member Level Detail

- Subscriber Number - Medicaid Recipient ID
- Member Policy Number
  - Identifies insured's group number
  - Provider ID

2000 Member Level Detail

- Medicare Plan Code
  - Identifies Medicare coverage
  - This element will be used to report Medicare coverage as known by MDCH
  - Replaces the use of Other Insurance (OI) codes
- Maintenance Reason Code on 834 update transaction
  - Used for MHPs and SHPs
  - Replaces reason codes on the weekly 4684

2000 Member Level Detail

- Member Identification Number
  - Used to pass further identifying information of member
  - Case Number (3H) will be used to transmit MDCH Case Number
  - Prior Identification Number (Q4) will be used to transmit Mother's Recipient ID for newborns to MHPs

2000 Member Level Detail

Member Level Dates

- Eligibility Begin (356)
  - Only way to enroll a member is with a 356 eligibility begin date
  - MHPs, SHPs, and PACE for new enrollment only
  - HKD, PHPs always transmitted
- Medicaid End (474)
  - Medicaid eligibility is in question
  - Historically this has been described as "Pending Negative Action"
  - Only MHPs, PACE, and PHPs

2100A Member Name Loop

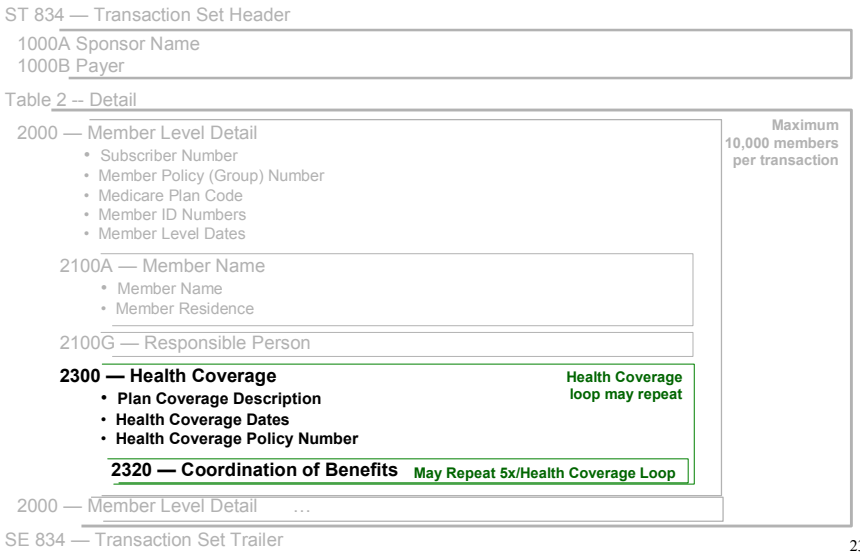
- Member name
- Member address
- When available, member's Social Security number will be transmitted
- Member demographics
  - Birth date
  - Gender
  - Race
  - Language

2100G Responsible Person

This loop is used to identify and provide contact information regarding the person responsible for the member

- MHPs, SHPs, PACE, and HKD –
  - Transmit Guardian (GD) name and address when available
  - Transmit Responsible Party information (QD) when there isn't a guardian
- PHPs – responsible person loop will not be transmitted

Table 2 – Detail Level



2300 Health Coverage

Plan Coverage Description

- This element is used when additional information is needed to describe the exact type of coverage being provided
- Element will only be used for MHPs and SHPs
- MHPs – Pregnancy indicator for maternal support services
- SHPs – Primary and secondary diagnosis codes and plan type code

2300 Health Coverage

Plan Coverage Description Examples

- MHPs: "N"
  - Member is not pregnant "N"
- SHPs: "_40413__4280___1"
  - Primary diagnosis code "40413"
  - Secondary diagnosis code "4280"
  - Plan type code "1"

2300 Health Coverage

Health Coverage Dates

- 834 transaction supports transmitting dates at both the member level and the health coverage level
- However, termination dates must not be transmitted at both levels
- Coverage dates will be transmitted in separate health coverage loops
  - When a member has more than one coverage with a single Plan (dual eligible -- SHP and MHP coverage) or
  - When coverage for a member has changed within a single Plan

2300 Health Coverage

Health Coverage Dates *(continued)*

- Benefit Begin (348)
  - Coverage effective date for specific health coverage
  - HKD and PHPs will only receive benefit begin dates
- Benefit End (349)
  - Removal of coverage
  - Termination of benefits
  - MHPs, SHPs, and PACE

2300 Health Coverage

Policy Number

- Scope
- Coverage
- Level of Care
- Program Code
- District Code (HKD only)

2300 Health Coverage

Policy Number Examples

- MHP or PHP: "1F07Q"
  - Scope "1"
  - Coverage "F"
  - Level of Care "07"
  - Program Code <alpha>
- SHP: "____1"
  - Scope <none>
  - Coverage <none>
  - Level of Care <none>
  - Program Code <numeric> for SHP (T-5)
- HKD: "_____1000"

2300 Health Coverage

Coordination of Benefits

- Policy number
  - Other insurance company's policy number
- Contract number
  - Typically, policyholder's Social Security number
- Carrier name
- COB begin and end date
  - Dates will be provided when available

2300 Health Coverage

Dual-Eligible Member Example

- Separate Health Coverage loops will be transmitted
- SHP - Health Coverage information includes:
  - Plan Coverage Description "_40413__4280___1"
  - Policy Number "____1"
  - Coverage Dates
  - Coordination of Benefits
- MHP - Health Coverage information includes:
  - Plan Coverage Description "N"
  - Policy Number "1F07Q"
  - Coverage Dates
  - Coordination of Benefits

820 Payroll Deducted and Other Group Premium Payment Insurance Products

Michigan Department of Community Health
April 17, 2003

820 Overview

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820 Overview

- HIPAA mandated transaction for reporting premium payment information
- MDCH will send the remittance information separate from the premium payment
- The 820 transaction will be transmitted on a schedule that is consistent with MDCH's current remittance reporting process

820 Overview

- The following provider types will receive the 820 premium payment transaction:
  - Medicaid Health Plans (MHP)
  - Children's Special Health Care Services-Special Health Plans (SHP)
  - Healthy Kids Dental (HKD)
  - Prepaid Health Plans (PHP)
  - PACE
- Maternity Case Rate payments will also be reported on an 820 transaction

Remittance Detail

- The HIPAA 820 transaction can transmit either:
  - Organization Summary Remittance

    or
  - Individual Remittance
- Organization Summary Remittance supports the reporting of premium payments via a gross adjustment
- Individual Remittance supports the process of reporting a specific premium payment associated with each recipient

820 Transaction Detail

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Table 1- Header Level

ST 820

- **Financial Information**
- **Reassociation Key**
- **Premium Receivers Identification Key**

1000A – Premium Receiver's Name

1000B – Premium Payer's Name

Header

2000A — Organization Summary Remittance

2000B — Individual Remittance

Detail

Summary

SE 820

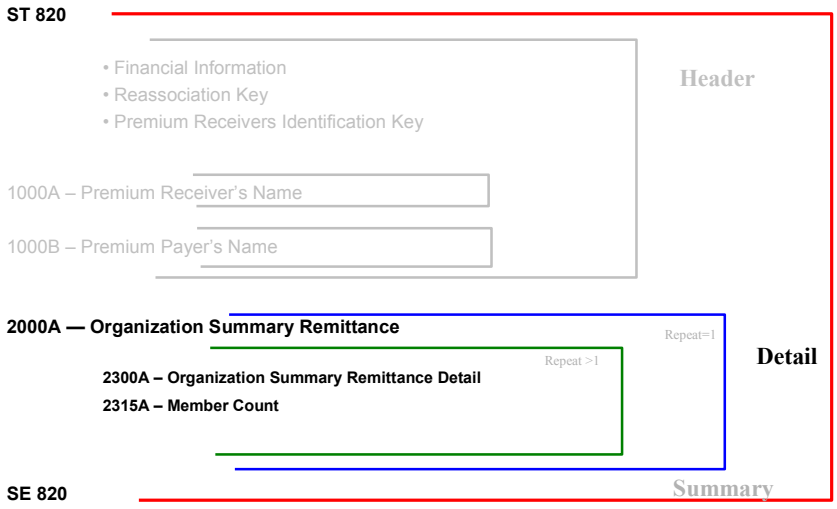
Table 1 – Header Level

- Financial Information
  - Total 820 transaction paid amount
  - Method of payment, either check (voucher) or EFT
  - Month for which payment is being made
- Reassociation Key
  - Check number or EFT trace number used for reassociating payment and remittance information
- Premium Receiver Identification Key
  - MDCH provider ID

Table 1 – Header Level

- Premium Receivers Name
  - Identifies the name of the Payee on the check or EFT
  - Provide Payee's Federal Tax ID
- Premium Payer's Name
  - Identifies the Payer (Department of Community Health)
  - Address: P.O. Box 30479
  - Administrative Contact phone number: 1-800-292-2550
  - Email address: Providersupport@michigan.gov

Table 2- Organization Summary



Organization Summary Remittance

- Supports the reporting of premium payments via a gross adjustment
- This method will be used to report PHP payments
- Currently a single payment is made to a PHP and summary information is reported by county and type of coverage
  - Mental Health (MH)
  - Substance Abuse (SA)
  - Developmentally Disability (DD)
- Provides a member count by county and type of coverage

Organization Summary Example

820 Header:

Provider ID: 1707176 Washtenaw

Fed Tax ID: 123-33-4444

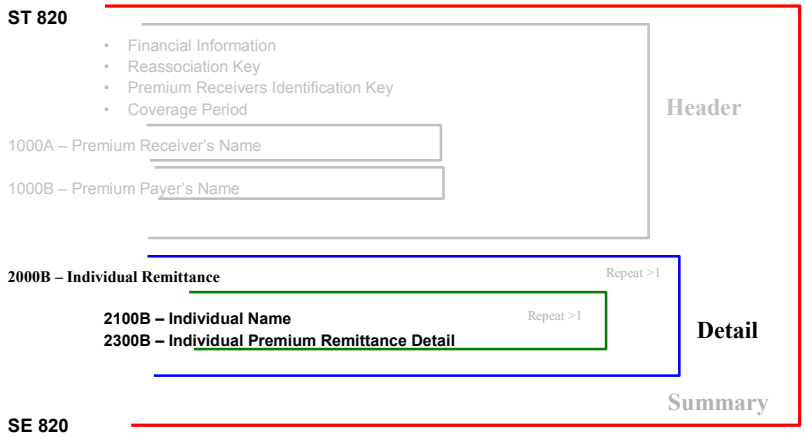
Organization Summary Remittance

Repeat=1

Type of Coverage/County	Pay Amt.	Member Count
Mental Health 46	1,000,000	100,000
Substance Abuse 46	800,000	75,000
Developmentally Disabled 46	1,500,000	30,000
Mental Health 47	500,000	50,000
Substance Abuse 47	400,000	45,000
Developmentally Disabled 47	1,100,000	20,000

Repeat >1

Table 2 -Individual Remittance



Individual Remittance

- Supports the process of reporting a specific premium payment associated with each recipient
- This method will be used to report the following premium payments
  - MHP
  - SHP
  - HKD
  - PACE
  - Maternity Case Rate
- Providers may have two provider IDs one for MCEP or Non-MCEP therefore a provider may receive two 820 transaction and two checks

Individual Remittance

- MDCH recipient ID
- Recipient first, middle, and last name
- Premium Remittance Detail
  - MDCH Claim Reference Number (CRN)
  - Premium payment amount
  - Coverage period for the paid amount
- Premium remittance detail can repeat for an individual

Individual Remittance Example

820 Header:

Provider ID: 3397152 Priority Health

Fed Tax ID: 123-88-4444

Individual Summary Remittance

Repeat=1

MDCH ID	Recipient Name	CRN Number	Pay Amount	Date	Repeat >1
1234567	Joe Smith	81881989	700	Jan	
		81881990	300	Feb	
2347882	John Doe	98989889	600	Feb	
2938293	Jane Smith	78787878	500	Feb	

Data Clarification Documents

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Data Clarification Documents

- Data clarification documents were created as a companion to the National Electronic Data Interchange Transaction Set Implementation Guides
- 834 data clarification documents:
  - MHPs and PACE
  - CSHCS -- SHPs
  - HKD
  - CMH -- PHPs
- 820 data clarification documents
  - Organization Summary Remittance
  - Individual Remittance
- Data Clarification Documents can be found on the MDCH web site: **http://michigan.gov/mdch**

Questions and Answers

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